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f. X Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the plan or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours;

g. X Not refuse an assignment or disenroll a participant or otherwise discriminate against a participant solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type;

h. X Request reassignment of the participant to another plan only because:

(1) X Patient/plan relationship is not mutually acceptable;

(2) X Patient's condition or illness would be better treated by another provider type;

(3) X Patient has more convenient access to primary care physician with another MCO.

(4) X Patient moves out of the Plan's service area.

(5) X Contractor determines that the willful actions of the enrollee are inconsistent with plan membership and the contractor has made and provides DMAHS with documentation of at least three attempts to reconcile the situation.

(6) X Contractor becomes aware that the enrollee's eligibility for Medicaid has been terminated.

i. X Notify the participant in a direct and timely manner of the provider's desire to remove the participant from the plan's caseload;

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j. _X_ Keep the participant as a client until another provider is chosen or assigned;

k. _X_ Be disenrolled as a Medicaid provider as a result of failure to comply with provider requirements;

l. _X_ Require that all subcontractors meet the same requirements as are in effect for the contractor; and

m. _X_ Comply with all State and Federal regulations governing MCOs.

20. The State will be entering into the following type of contract with the MCO.

a._X_ Risk-comprehensive contract.

(1) The contract complies with section 1932(a) of the SSA.
(2) The contract complies with section 1903 (m) of the SSA.
(3) The contract complies with 42 CFR Part 434.
(4) The contract complies with actuarial soundness and upper payment limits requirements in 42 CFR 434.23 and 42 CFR 447.361.

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21. Since risk-comprehensive contracts will be in effect, the following additional requirements will be met:

a. X — There will be an open enrollment period during which the MCO will accept individuals who are eligible to enroll.

b. X — Enrollment is voluntary for these populations: SSI and SSI-related beneficiaries who are dually eligible for Medicare and Medicaid; children under 19 receiving foster care or adoption assistance who the State is otherwise covering who are eligible under Title XIX State Plan; children under 19 years of age who are described in section 1902(e)(3) of the Social Security Act, children under 19 years of age who are receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V, i.e., children who have birth defects, chronic disorders, developmental delay, or who may be at risk of developmental disabilities; and Indians who are members of Federally-recognized tribes.

c. X — MCOs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

d. X — The MCO will not terminate enrollment because of an adverse change in the recipient's health.

e. X — A disenrollment will be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment.

f. X — An enrollee may disenroll during the remainder of any period of enrollment following the first three months,

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(1) _X_ If the MCO approves the enrollee's request to disenroll;

(2) _X_ Or, if all of the following requirements are met:

(a) _X_ An enrollee requests in writing to the State and the MCO for good cause;

(b) _X_ The request cites the reason(s) why he or she wishes to disenroll such as poor quality of care, lack of access to specialty services, or other reasons satisfactory to the State;

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(c) X The MCO provides information that the State may require; and

(d) X The State determines that good cause for disenrollment exists.

g. X An MCO will inform each recipient at the time of enrollment of the right to disenroll no less than twice a year and at least 60 days before the start of each new period of enrollment.

h. X An enrollee will be allowed to choose his/her health professional in the MCO to the extent possible and appropriate.

22. FQHC services will be made available to recipients in the following manner:

a. X The program is mandatory, and the recipient is provided reasonable access to FQHC services under the program.

23. The following process is in effect for recipient enrollment in an MCO.

a. X The recipient is provided with:

(1) X A brochure explaining the program;

(2) X A form for enrollment requesting prior physician relationships and selection of a plan;

(3) X A brochure which lists the plans serving the recipient's geographical area and describes the benefits provided by each MCO:

(4) X A toll-free number to call for questions;

(5) X Information explaining the grievance procedures;

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(6) X Quality and performance measures via CAHPS brochure comparing information among MCOs. Note: Future plans include issuing formal report cards on selected MCO quality and performance measures based on State and external quality review organization quality studies.

b. X The recipient notifies the State by mail or telephone of choice of plan.

c. X Certain Medicaid eligibles who reside in enrollment areas that have been designated for mandatory enrollment and who do not voluntarily choose enrollment in an MCO, will be assigned automatically by DMAHS to an MCO.

The Auto Assignment Process operates in the following manner: The Medicaid Eligibility File is run weekly and newly eligible Medicaid beneficiaries are identified from this file. All of the newly eligible Medicaid beneficiaries that are identified are sent a managed care Newly Eligible Enrollment Kit within 7 days. At the time the kit is sent, the beneficiary is also auto assigned to an HMO with an effective date two months in the future. During the time period before auto assignment is effective, at least 3 outreach efforts are made and can include mailings, appointments and final reminders sent to the beneficiary to encourage beneficiary selection of an HMO. If the beneficiary chooses an HMO, the auto assignment is voided. If the beneficiary does not choose, the auto assignment becomes effective and the beneficiary's enrollment in the auto assigned HMO becomes effective. Persons who fall into an "excluded" category are not eligible to enroll in the MCO and will not be automatically assigned. The auto assignment system is programmed to bypass those identified excluded categories utilizing various indicators, e.g. , special program code, program status code, Medicaid Identification Number, Third Party Liability (TPL) segment, lock-in indicator, etc.

d. X The plan will be informed by mail or telephone or electronic interface of the participant's enrollment in the Plan.

e. X The recipient will be issued a card which includes the MCO's name and telephone number.

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f. _X_ A record will be kept of what special services are offered by MCOs, such as different languages, interpreting services for the deaf, etc. Participants will be advised as to what providers offer any such special services that are needed.

g. _X_ The program educational material will be translated into other languages as necessary, such as Spanish.

B. QUALITY OF HEALTH CARE AND SERVICES (INCLUDING ACCESS)

1. To assure quality of health care services in this program, Medicaid shall:

a. _X_ Require, by contract, that all MCO providers meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434;

b. _X_ Monitor, on a periodic or continuous basis (specified below), all MCOs' adherence to these standards, through the following mechanisms:

(1) _X_ Review of each plan's written QAP to monitor adherence to the State's QAP standards. Such review shall take place prior to the State's execution of the contract with the Plan and annually thereafter;

(2) _X_ Periodic review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. These data will be submitted by plans on a quarterly basis;

(3) _X_ On-site (at the MCO administrative offices and/or care delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's QAP standards. Such monitoring will take place annually for each plan;

c. _X_ Conduct monitoring through the use of:

(1) _X_ Medicaid personnel; and

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(2) _X_ Department of Health and Senior Services, the State regulatory agency which has general QA oversight of MCOs.

2. For all MCOs, Medicaid will arrange for an independent, external review of the quality of services delivered under each managed care organization's contract. The review will be conducted for each MCO on an annual basis. The entity which will provide the annual external quality reviews is not a part of the State government, and is not a managed care organization or an association of managed care organizations. The entity is:

a. _X_ An accredited peer review organization.

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3. Recipient access to care will be monitored as part of each plan's internal QAP and through the annual external quality review. The State will include the following activities as part of the periodic medical audits, external quality review or State monitoring activities. Check any that apply.

Legend: S=State, I=Internal MCO QAP, E=ERO

a. ____ Periodic comparison of the number and types of Medicaid providers before and after the waiver;

b. S,I Periodic recipient surveys which contain questions concerning recipient access to services;

c. S,E Measurement of waiting periods to obtain health care services;

d. S,I,E Measurement of referral rates to specialists;

e. S,I Assessment of recipient knowledge about how to obtain health care services;

f. S Measurement of access to services during and after a plan's regular office hours, e.g., through random phone calls to plans;

g. S,I,E Measurement of access to emergency or family planning services;

h. S,I Measurement of recipient requests for disenrollment from a plan.

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4. In addition to the above processes, recipient access to services will not be impaired because of the following:

a. X — Recipients may choose any of the participating plans operating in their counties of residence. The SSI and DDD/CCW beneficiaries, may cross county lines and choose any MCO as their managed care plan. In addition, as per 42 CFR 434.29, within a plan, each Medicaid enrollee has a choice of health professionals to the extent possible and feasible.

b. X — The same range and amount of services that are available to fee-for-service recipients are available to managed care enrollees.

c. X — Distances and travel time to obtain services for recipients under managed care will not substantially change from that of the fee-for-service program.

d. X — The number of providers participating in the managed care program compared to fee-for-service is expected to remain the same or increase.

e. X — Case management, primary care, and health education are provided to enrollees by a chosen or assigned plan. This fosters continuity of care and improved provider/patient relationships.

f. X — Preauthorization is precluded for emergency and family planning services under this program.

g. X — Recipients have the right to change plans if the arrangement is not satisfactory for good cause at any time.

h. X — Plans are required to provide or arrange for coverage 24 hours a day, 7 days a week.

i. X — The same grievance system which was in effect under the regular Medicaid program will be in effect under managed care. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E.

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j. X — In addition to the grievance system specified in paragraph i. above, the plan has its own system for handling complaints and grievances.

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